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### **A Unique Low-Cost Private Health Insurance Program in Namibia: Protection from Health Shocks Including HIV/AIDS**

Janssens, W.; Gustafsson-Wright, E.J.E.; de Beer, I.; van der Gaag, J

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# Social Security in Africa

## **Also in this issue:**

Feasible Social Security Systems in Africa

Social Health Insurance: how feasible is its expansion in the African Region?

A Unique Low-cost Private Health Insurance Program in Namibia

# DevISSues

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## From the Editorial Board

### Social Security in Africa

This issue is devoted to the theme of providing Social Security in Africa. In most rich countries social security systems are today taken for granted. Although they differ in their generosity across countries, in most cases they provide a minimum of compensation in the event of illness, unemployment or retirement. In Africa, the implementation of these kinds of safety nets has just started and only in a few countries at that. Moreover they often only cover a small share of the total population in need.

The lack of insurance against daily risks such as illness, unemployment, natural disasters, crop failures and such like can have serious short term and long term consequences for the concerned households, in particular because alternative coping instruments such as credit or savings are also not available or are at least not accessible to the poor. Consider the case of a severe illness. A household which has to finance the costs for treatment out of current income can be confronted with a transient period of poverty, whereby other expenditures such as for food, energy, children's education or clothing have to be scaled back. Financing such costs through the depletion of assets can reduce future earning capacity or make the household more vulnerable to future shocks. If the household decides to forgo treatment altogether, the health status will decline and probably also adversely affect earning capacity.

The implementation of social security is particularly difficult in Africa, because most of the countries in that region face serious budget constraints, making it almost impossible to finance often rather expensive insurances systems. In addition, the implementation and management of social security systems requires quite complex institutions which, again, are not available in most of these countries. Therefore it is important to explore how both problems can be tackled and to think about alternatives which could be used in the meantime.

This issue considers these questions and draws on experiences which can help to find answers. Arne Tostensen explores alternative social security systems adapted to the African context. Guy Carrin and colleagues consider in particular the case of social health insurance and reflect on various recent experiences in Africa. Michael Grimm summarizes a discussion on health insurance systems targeted at the poor which was held at the Annual World Bank Conference on Development Economics in 2008. Wendy Janssens and co-authors share their experience with the implementation of a pilot program introducing the concept of low-cost private voluntary health insurance products in Namibia. Finally, Mahmood Messkoub discusses possibilities to provide old-age security to the ageing African population. We hope these papers make a useful contribution to the burning questions and provide a signal to policy makers and practitioners that insurance against daily risks should be a central element in any poverty alleviation strategy.

*Michael Grimm, Guest-editor*

Considering the major upheavals taking place in the global economy right now, we couldn't bring out DevISSues without paying some attention to it. This issue therefore includes two shorter articles which consider the economic crisis from different angles. The first is by the Rector of ISS, Louk de la Rive Box, who considers what the crisis means for civil action and the second is by Karel Jansen who wonders what effect the crisis will have on the West's relationship with developing countries.

As we approach the end of the academic year for our Masters participants, we have to say thank you and good bye to the two student reps on the editorial board; Karoline Kemp and Achmad Uzair. Both have been active members of the board and have spent much of their precious spare time working on DevISSues. We wish you both the best of luck in the future. We also welcome the new representatives; Chantelle de Nobrega and Nick Glockl from the 2008-2009 batch.

Another good bye is to Thomas Tichar, editor of DevISSues until May of this year. Thank you for all your hard work and good luck with your future projects. His role has been taken over by Jane Pocock who took up the position of editor of DevISSues in September this year.

### About the cover

Gertrude from Kyanja parish-Nakawa Division in Uganda is 78 years old, blind and has lost all her children to AIDS. Her husband died 10 years ago. She was looking after four orphaned grandchildren but they left once she was unable to continue caring for them. Gertrude spends her day sitting in front of her shack begging passers-by for money and food. She was recently given some clothes from a new church near her home but receives no other State or NGO aid. The story of Gertrude brings home the difficulties faced by many poor, elderly people in Africa who have no family to turn to and no social security system to help them meet even their most basic needs.

*With thanks to Ddungu Racheal Mugabi for use of the photo.*

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# Feasible social security systems in Africa

Dr Arne Tostensen

*Chr. Michelsen Institute, Norway*

Increasing attention is being devoted to social security in developing countries as part of their poverty reduction strategies. This note discusses social security arrangements in sub-Saharan Africa to mitigate the unexpected adversity facing the masses of poor people. It is argued that for a social security system to be feasible in circumstances of severe budget constraints, formal and informal mechanisms must be combined.

Apart from deprivation in terms of income and consumption, a defining criterion of poverty is vulnerability to shocks and contingencies. These include natural and ecological calamities (droughts, floods, earthquakes, epidemics, pests, etc.) and human-made disasters and adversity of economic, social or political nature (wars, civil strife, market collapse, loss of income earners, etc.). To withstand economic shocks and crises, households must be able to survive such periods without irreversible damage to the productive capacity of their members and to their net asset position. In other words, vulnerability is not only related to coping with the sudden and temporary loss of income, but equally much to the wherewithal to recover after the shocks and to restore livelihoods to the pre-shock level. Social security arrangements are intended to assist poor households to overcome such temporary adversity.

## THE NORMATIVE FOUNDATION

The right to social security was enshrined in Article 22 of the Universal Declaration of Human Rights. ILO Convention no. 102 of 1952 specifies further a series of minimum standards. These rights were subsequently reconfirmed in Article 9 of the International Covenant on Economic, Social and Cultural Rights from 1966 which recognises "the right of everyone to social security, including social insurance".

The actual fulfilment of these obligations varies widely across the globe. In most industrialised countries elaborate welfare states have been established which afford the citizens generous social protection. However, in this regard the predicament of sub-Saharan Africa is particularly egregious. With reference to developing countries, the Committee on Economic, Social and Cultural Rights recognises in its authoritative General Comment no. 6 that the full implementation of Article 9 can only be done "within the limits of available resources" which, in turn, means only the "progressive realisation" of this right over time. In other words, the Covenant concedes that the obligations of the signatories as the duty-bearers are not expected to be met immediately; the process seems open-ended.

## WHAT IS SOCIAL SECURITY?

The International Labour Organisation (ILO) defines social security as:

*... [t]he protection which society provides for its members, through a series of public measures, against the economic and social distress that otherwise would be caused by the stoppage or substantial reduction of earnings resulting from sickness, maternity, employment injury, unemployment, invalidity, old age and death; the provision of medical*

*care; and the provision of subsidies for families with children.*

However, this conventional definition is deficient in two respects. First, it places undue emphasis on the role of the state on social security provision. Second, it presumes that the majority of the citizens have already attained a satisfactory living standard in a modern economy, which social security is designed to protect. The referent is obviously Western societies which hardly fits the contemporary African situation.

A more appropriate definition would embrace all forms of social security in varying configurations of traditional, informal and formalised modern forms. In other words, social security would encompass the sum of all regulations within a society which aim to guarantee the individual or the group not only physical survival, but also general protection against unforeseeable risks which would entail the deterioration of their situation, the consequences of which cannot be borne by the individual or group without external assistance.

Most African economies are agrarian, with the majority of their populations deriving an income as self-employed smallholders. The small size of their plots and the vagaries of the weather as well as an array of other contingencies make them very vulnerable to economic

shocks. Since most social security arrangements cater only for the formal economy this means that, in terms of coverage, the overwhelming majority of Africans remain unprotected by formal means against the main risks.

In these circumstances, from what sources do Africans actually derive social security? Large segments of African populations do not enjoy social security at all; they are at the mercy of nature and human forces beyond their control. Traditionally, however, the collective solidarity of the extended family, clan and ethnic group was the mainstay of income and social security. These collective, community-based social security arrangements are based on systems of mutual dependence or reciprocity. But this stylised representation of traditional society is fast disappearing.

Four broad types of institution have evolved to provide social security in the African context: the state; the private market; civil society; and the family. From an institutional perspective the principal difference between these sources of social security is found in their underlying incentive structure of co-operation and compliance. The state relies on legislation and compulsion, whereas the market depends on economic incentives. By contrast, civil society social security arrangements are predicated on mutual interest and peer pressure, while the family provides cohesion based on deep-seated social norms and values.

## DIFFERENT SOCIAL SECURITY INSTITUTIONS

Social security provision in developing countries has evolved by default rather than by design. Since developing countries still find themselves in a transitional phase, traditional forms of social security co-exist with modern ones, supplemented by 'in-between' variants of an informal nature.

### **State-based systems**

State-based social security systems are modelled on European experiences and cater for people in the modern sector of the economy, i.e. only for those in organised public and private employment. For example, social insurance pension schemes and provident funds typically cover only 5–10

percent of the total labour force plus their dependants.

A distinction is normally made between *social assistance* and *social insurance*. The former is defined as benefits in cash or in kind financed by the state (at central or local level), as a rule provided on the basis of means-testing. Typical examples are so-called safety nets for poor people in need. The concept also includes universal benefit schemes which are not means-tested, e.g. child and family support. Social assistance is non-contributory, i.e. the beneficiaries do not contribute in advance of drawing benefits. It is funded from general tax revenue.

By contrast, social insurance as a form of social security is financed by contributions and is based on the insurance principle, which means the elimination of uncertainty associated with loss for the individual or the household. This is achieved by pooling the contributions of a large number of similarly risk-exposed individuals or

households into a common fund that compensates the loss experienced by any member. In other words, resource-pooling and risk-sharing are defining characteristics of social insurance schemes which by nature are collective. As such they contain an element of redistribution. But they may be administered either publicly by the state or privately by insurance companies. Social insurance schemes may be compulsory or voluntary.

One of the main social protection problems in Africa is coverage. The economic conditions are such that the prospects are bad for the introduction of tax-based social assistance schemes. The number of poor is simply too large and the tax base too narrow. Contributory health insurance schemes suffer from similar problems, mainly because of the unpredictability of benefits and the adverse selection problem. The prospects are somewhat better with respect to contributory pension schemes. A convincing case can be made for the judicious extension



Only workers in formal employment are covered by official social security schemes. Jean Christophe Goussand

of coverage in order to improve the financial base. More contributors mean greater revenue immediately while the payable benefits may be deferred into the future. However, the governance and management of public social security institutions are the main hurdles. There are deficiencies in record keeping and the processing of benefit claims.

### **Market-based systems**

Complementary market-based social security schemes run by private insurance companies on a commercial basis have emerged alongside state-based systems, even though they still play a marginal role in the total provision of social security. While the efficiency and quality of commercial social insurance systems are recognised, their inaccessibility for the low-income strata renders them suitable instruments mainly for the affluent, urban-based parts of the population. Pressures to privatise social security have not really taken hold in Africa. Statist traditions are resilient and social security is considered such an essential service that the state prefers to retain it under its umbrella.

### **Membership-based systems in civil society**

An array of membership-based schemes has emerged in civil society. They fill a gap left by the state and the market. The distinguishing criteria of these schemes are their internal homogeneity and limited size. Those who form such groups have something in common that bind them together in mutual interest: kinship or ethnicity; geographical origin, or friendship. And they are small enough to be manageable. These mutual-help societies take a multitude of forms. All over Africa, the best known are perhaps the informal rotating savings and credit associations (ROSCAs). The basic principle is the same everywhere: a fixed sum is paid periodically into a common pool by each member. From this pool each member may withdraw at fixed intervals a lump sum equal to his/her own contribution multiplied by the number of members. Thus, each member has rotating access to a continuously replenished pool of capital. The pool may run for a short while, only a few months, or extend over several years; it may involve small sums of money or considerable amounts; the members may be few or many; it may

comprise a mixture of members, only women, only men, urban dwellers or rural peasants. The variants are legion but the basic principle remains the same. Most ROSCAs are perhaps not primarily social security institutions. As a rule, the withdrawn money may be used for any purpose. Some members use it for investment, others for pure consumption items, and still others to withstand hardship in social security contingencies (illness, accident, death, unemployment, etc.). As such they constitute an important informal social security mechanism, which enables poor people to deal with contingencies.

A second, slightly more formalised type of social security arrangement is organised along co-operative lines. Savings and credit co-operatives (SACCOs) are often linked to the workplace. Small deductions are made regularly from the wage, and after a stipulated period the contributor is allowed to withdraw, say, three times his/her contribution. Repayment is also through a wage deduction. Again, there is generally no restriction on the use of the loan and many borrowers use the money to meet contingencies.

At present, social security arrangements hardly exist for the great majority of self-employed peasants in the rural areas. There is some scope, however, for crop-based schemes. To finance basic social protection, levies could be imposed on cash crops delivered to co-operatives or other marketing organisations. The design of such schemes could be negotiated by the peasants in conjunction with the officers of their organisations, probably with technical assistance inputs from outside.

More or less formalised NGOs also perform social security functions but they appear to be less important than ROSCAs and SACCOs. Be that as it may, there seems to be scope for strengthening the role of NGOs in social security provision. Trade unions are particularly well placed in that regard, but their disadvantage from the point of view of coverage is that they are confined to the formal sector of the economy.

All the above civil society forms of social security have an untapped potential, and with concerted efforts their relative

importance could grow. Some would argue that the state should leave them alone lest they become 'contaminated' and acquire the same problems that have beset the state-based schemes. On the other hand, judicious, unobtrusive technical assistance might be in order to improve management and enhance efficiency.

### **Kinship-based systems**

Finally, the support system of the extended family is still alive in Africa, albeit under increasing pressure. First, the productive resources an average household commands are diminishing, mainly due to the sub-division of land from one generation to another. Second, household expenditures are soaring with respect to education, health and other services. Third, the dependency ratio is increasing due to unemployment, high fertility rates, children orphaned by AIDS, and the destitution of relatives. All this constrains the ability of households to contribute to informal social security networks, simply because there is little to spare. Social security systems are sensitive to such demographic parameters: fertility, mortality and population growth rates, as well as age structure and the impact of the HIV and AIDS pandemic.

### **CONCLUSION**

The prospects for feasible social security systems in sub-Saharan Africa do not appear encouraging. In the circumstances, the only practicable way forward is to combine the four main tiers of social security, and devise a new division of responsibility between public and private provision. At any rate, whatever new 'blends' may emerge they must be closely tailored to the needs and conditions of each country. Judicious expansion of state- and market-based schemes is no doubt feasible, with emphasis on contributory arrangements. The problems of collection, administration, investment and general governance are tough but not insurmountable. The real challenge, however, lies in expanding the membership-based arrangements of civil society, including crop-based schemes to capture the vast majority of smallholders who generally fall outside existing systems.



# Social health insurance: how feasible is its expansion in the African region?

by

**Guy Carrin**

*World Health Organisation*

*HQ, Geneva*

**Ole Doetinchem**

*World Health*

*Organisation HQ,*

*Geneva*

**Joses Kirigia**

*World Health*

*Organisation/AFRO,*

*Brazzaville*

**Inke Mathauer**

*World Health*

*Organisation HQ,*

*Geneva*

and

**Laurent Musango**

*World Health*

*Organisation/AFRO,*

*Gabon*

## **A DUAL CHALLENGE: IMPROVED ACCESS TO BETTER HEALTH CARE**

In most economically advanced countries, adequate social security laws are basically taken for granted. However, it often took many decades for social security systems to benefit all or major parts of the population in those countries. In the area of social health protection, for example, it took Japan 36 years to move from the enactment of the first health insurance law to the final law establishing nation-wide social health insurance. In the United

Kingdom, a similar time period was needed to achieve its universal tax-based system.

A key question now is whether African countries can take shorter routes to *universal health coverage*, rather than going through a lengthy transition period. Universal health coverage means that all of the population has access to appropriate health care when needed and at an affordable cost. Leapfrogging will be far from easy, as many African countries face the dual challenge of enhancing their overall health expenditure level and of drastically improving access to and quality of health care. *First*, noting that a basic set of health services would cost at least \$ 34 per capita, many of the 46 WHO member states in the African region fall short of this objective. In 2005, 29 countries spent less than this amount. *Secondly*, problems of access to health care are pervasive and are linked to the level of households' out-of-pocket payments for health care: high out-of-pocket payments deter people from seeking care. In Kenya for example, out-of-pocket payments represented about 50% of total health expenditure in 2003. The results from a Kenyan household survey in the same year showed that 24.9 % and 24.7% of patients did not use outpatient (ambulant) and inpatient (hospitalized) care, respectively, although they needed it. About 40% of these patients reported they could not afford the out-of-pocket payments charged for these categories of care.

## **THE POTENTIAL ROLE OF SOCIAL HEALTH INSURANCE**

The challenge is: how to achieve both a higher level of expenditure and a lower level of out-of-pocket payments? There has been the call by African heads of state to allocate at least 15% of annual government budgets to the health sector, referred to as the Abuja Declaration. In addition, if the existing international commitments are fulfilled it is expected that this financial support would indeed increase substantially over the next decade. Both enhanced domestic and external funding for

health would boost health systems, not only in terms of improved quality of health care, but would also shift away from out-of-pocket payments to 'prepayment of health care'. Health financing via prepayment implies that people are not deterred from seeking care and at the same time are protected against the financial risks of falling ill, as the burden of patients to pay out-of-pocket will be eliminated or substantially reduced.

There are a number of alternative ways to achieve universal health coverage via prepayment. When governments are the only responsible financing agents for the transition to universal health coverage, one usually speaks of a tax-based health care system. Another mechanism is social health insurance (SHI), which in its mature form involves compulsory membership among all of the population. Principal funding is via earmarked contributions by employees and their employers, civil servants and government (as their employer), and the self-employed from the formal and informal sectors of the economy. The base for the contributions of employees, civil servants and employers is usually the employees' or civil servants' salary. The contributions of the self-employed are often either flat-rate or based on estimated income. However, hybrid forms of SHI are also quite prevalent, with government paying contributions for those, such as the unemployed and the poor, who would otherwise have difficulties in contributing. Another important characteristic is that health care provision financed by SHI is often mixed, based on both the public and private health care sector. Furthermore, for its management functions (such as member registration, collection of contributions, contracting with and reimbursement of providers), SHI may also be organized by parastatal or non-profit organisations such as sickness funds.

## **AFRICA'S RECENT INTEREST IN SOCIAL HEALTH INSURANCE**

SHI is not a widely adopted health financing mechanism in Africa. While there are many countries that



operate a health insurance scheme for civil servants and/or private sector employees only some of these include features of a SHI, its appeal to cover larger parts of the population has been growing. Countries including Ghana, Nigeria and Rwanda have passed SHI laws. Earlier on, Kenya investigated the feasibility of SHI and Lesotho and Swaziland are doing so now. What could explain its attractiveness? One distinct feature is that it does not call exclusively on public finance, but instead spreads the responsibility of health care financing among households and the private sector as well. From that point of view, tax-based systems in Africa are particularly challenged: the overall tax base may need to be strengthened, tax compliance may require improvement, and then a sufficient allocation towards health would have to be called for. Still, social health insurance is not a panacea either. It requires that an important organizational apparatus be put in place and that many actors in society shoulder critical responsibilities, such as the willingness and ability to contribute to the SHI scheme and then to comply with its regulations, thereby accepting a certain degree of financial solidarity.

## FEASIBILITY ANALYSES OF SOCIAL HEALTH INSURANCE

Since 2002, the WHO has been involved in technical advisory work especially on assessing the feasibility of SHI in Kenya, Lesotho and Swaziland in collaboration with national experts from those countries. In each country we analysed the financial, organizational and political feasibility. Below we present some of the highlights of this work that should help us in formulating general guidance.

In *Kenya*, one basic financial scenario was that of gradual implementation of universal health coverage: coverage by a possible National Social Health Insurance Fund (NSHIF) would reach 62% of the population after 10 years, with further expansion in the second decade of SHI implementation. An important feature is that such a scenario would only be conceivable with sizable government subsidies. Without such subsidies, access to health care among low-income households would be jeopardized, as the contributions from formal sector employees and civil servants would be insufficient to cross-subsidize the needed health care of the

poor. External donors' financial support, however, could alleviate this extra financial burden on government. In fact, a variant of the basic scenario assumes that external donors would finance the provision of antiretroviral therapy, which would reduce the required government subsidies by about 20%.

As far as the organizational aspects are concerned, it was studied whether the existing National Hospital Insurance Fund, a mandatory hospital insurance scheme for the formal sector with a small part of voluntary insurance for informal sector workers, might be transformed into the NSHIF. The latter would then be governed by a Board of Trustees with representatives from civil society. It is also interesting to note that the proposed NSHIF would include a Department of Fraud and Investigation in order to check the fund's financial activities. Civil society groups and enterprises such as the Post Office would also be given a role, especially in the collection of contributions from households in the informal sector.

Concerning its political feasibility, consultations were held with a great number of stakeholders and interest groups, and most were supportive of the proposed NSHIF. Only Kenya's private Health Maintenance Organizations were very critical and had doubts about NSHIF feasibility. Finally, in 2004, the Kenyan Parliament passed a law on the NSHIF. However, President Kibaki judged it still needed amendments and returned it to Parliament for further debate that is still ongoing. Nonetheless, with a long-term vision, the existing National Hospital Insurance Fund is undertaking a number of institutional changes to increase membership and extend benefits so as to be better prepared should SHI take off.

*Lesotho's* priority concerns are to improve the quality of and access to health services, especially to the poorer half of the population. To this end, the country wants to raise the amount of money it can spend on health through SHI and decrease user charges to reduce out-of-pocket expenditure. Of the several financial scenarios discussed, stakeholders found the one that aims to extend SHI coverage across the whole population most attractive. This scenario

envisions a rapid implementation of SHI for the formally employed, while gradually extending this to the rest of the population over the course of a decade. Almost half the population would be exempt from having to pay owing to poverty. Current spending on health from tax sources would be maintained and supplemented with SHI funding. The combined funding would allow a substantial investment in improved quality health services.

As coverage increases and more poor people join, the financial balance of the SHI would tip towards deficit after some seven years. This would require subsidies and/or a raise in contribution rates for the formal sector.

Lesotho's stakeholders, including the government and civil society, are debating whether or not to go ahead with such a system. The implication that needs to be accepted first is that a SHI would institutionalize a cross-subsidy from rich to poor. Today, those who can afford it usually purchase health services in neighbouring South Africa, but a SHI would only allow a select number of medically essential referrals. Services over and above what the Lesotho SHI system is scheduled to offer would still need to be paid for privately. Everyone would, however, be contributing to the SHI, so that the cost of providing and improving services would be spread between households, enterprises and government. How exactly the money would be best spent to achieve these goals would be the next question to tackle.

Similarly in *Swaziland*, given the concern about the poor quality of care in the government sector, the feasibility assessment of a SHI served to provide alternative options to the existing private medical aid scheme now under discussion for civil servants (a private health insurance scheme). Another challenge of the current health financing system is the high expenditure on and the insufficient organization of medical referrals to South Africa. Thus, the Ministry of Health's objective of introducing SHI is to ensure universal access to health care by mobilizing additional resources to finance quality improvements, particularly in the public sector, as well as to build up tertiary, specialized care within Swaziland.

With a small population of about one million, the key stakeholders preferred a scenario in which gradually all population groups would join the SHI scheme to achieve universal access after six years. About a fourth of the population would be exempted due to reasons of inability to pay contributions. A key assumption for this health financing system is that the government's budget for health care would be maintained and increase in line with GDP growth. The SHI scheme would then mobilize approximately another 50% of the government's budget for health. With these additional resources, significant quality improvements and increased utilization by the population could be financed.

The key challenge now being debated is implementation feasibility: can quality of health care at government facilities be improved within a few years to such a level that the population finds it acceptable to make contributions of around 6 to 7% of salaries? Another political challenge is that many representatives of the stakeholders and negotiating parties, as part of the upper middle class, have a strong interest in receiving access to the private health sector, with universal health coverage and solidarity appearing to follow as secondary objectives. It is now upon the government to take a decision, which also strongly depends on which financing scheme - a private health insurance or a SHI - the civil servant unions prefer.

#### **IMPLEMENTING SOCIAL HEALTH INSURANCE POLICIES: THE CASE OF RWANDA**

Aiming at universal health coverage for its 9.5 million population, Rwanda has spearheaded the development of a number of schemes that together constitute its SHI system. The three most important ones are the *Rwandaïse d'assurance maladie* (RAMA), the Medical Military Insurance (MMI) and the *Assurances Maladies Communautaires* (AMCs). The RAMA social health insurance is compulsory for government employees and voluntary for private sector employees. Its contribution rate is 15% of basic salary (shared equally between employee and employer). MMI covers all military personnel, who pay a contribution rate of 22.5% of basic salary (5% paid by

employee and 17.5% by government). AMCs are community-based health insurance schemes whose members are mainly rural dwellers and informal sector workers in both rural and urban areas. They make up the majority of the population; by the end of 2007 about 5.7 million Rwandans were covered by AMCs. Members usually contribute 1000 Rwandan Francs (1.85 US\$) per person per year which is matched by the government (with external donor support).

An important innovation has been the launch and extension of the AMC. Despite its voluntary character, the AMCs have benefited from a steady increase in membership. One of the principal factors of this success has been the collaboration among all stakeholders, and especially the financial support from government and external donors. Still, the AMCs face many challenges including making contributions more affordable to the poorest and improving financial management capabilities.

In general, there is the challenge to further reduce the fragmentation in this SHI system, but overall progress is steady. Rwanda has developed a legal framework for governing social health insurance and continues with its expansion. In particular, a recent law (April 2008) stipulates the future requirement of compulsory health insurance for every Rwandan.

The results of Rwanda's efforts in building up a SHI system can also be seen from the improvement in several health financing indicators, which include a greater availability of financial resources for health (34\$ per capita in 2007 vs. 13\$ in 1999), an increased coverage of the rural and informal sector population by the AMCs (from 1.2% in 1999 to 75.6% in 2007), and a lower burden of out-of-pocket payments (from 24.7% of total health expenditure in 2000 to 15.9% in 2005).

#### **WHITHER SOCIAL HEALTH INSURANCE IN THE AFRICAN REGION?**

The feasibility studies summarized above indicate that there is a certain potential for social health insurance in the respective countries. This reflection is reinforced by the positive outcomes

from the social health insurance policies in Rwanda. However, we can not merely generalize this assessment to the African region as a whole. Indeed a number of conditions for adequate implementation of SHI need to be satisfied. The prerequisites for success are vital and should once more be emphasized. First, financially speaking, with contributions from all stakeholders, sometimes including external donors, SHI can indeed be a vehicle for universal health coverage. The assumption here, however, is that countries' overall income level and income growth are sufficient, enabling households, enterprises and government to make contributions commensurate to their legal obligations. Secondly, sustained external donor financial support would strengthen the revenue base of the SHI schemes. Furthermore, sustained efforts would be needed to build new SHI-related organizations and reinforce administrative capacities to manage them. Crucially, progress with implementation will depend on political consensus and effective collaboration between stakeholders. In particular accepting a minimum degree of solidarity involving pooling of contributions and risks from all groups in society is a must.

Fulfilling all prerequisites may be a tall order, and it stands to reason that a transition period to a mature social health insurance system may last a decade or more. Having said all this, one should not forget that SHI is not the one and only method for reaching universal health coverage. Quite a number of possible paths exist with mixes of SHI, tax-based funding, community-based and private health insurance. Each country will have to decide what is most optimal in its own context. Should SHI be adopted, there is no doubt that implementation will be accompanied by various challenges of a political, organizational and financial nature. These should not discourage countries, however. A perfect road to universal health coverage does not exist. In fact, international experience shows that the development of SHI in the now high-income countries was far from smooth. In the meantime, the experience of countries such as Rwanda is noteworthy and promising.

# Securing access to health

## A session report from the Annual Bank Conference on

Michael Grimm

Today it is widely recognized that serious health problems ("health shocks" hereafter) and lack of financial protection from the consequences of these problems are important determinants for poverty. This link is reinforced by the fact that often poverty itself increases the exposure to health shocks. There is wide empirical evidence that reducing the risk from shocks, by relaxing short term credit and resource constraints, is crucial for increasing private productivity and investments which in turn should stimulate economic growth and reduce poverty. With regard to health, one can typically see an unequal distribution of utilization and quality of health care in developing countries. It is mainly the poor that forgo treatment, where health care is mainly financed by out-of-pocket payments and the foremost barrier to access to health care is affordability. In case of unexpected health expenditures associated with health shocks, a lack of financial protection can lead either to poor households to forgo health treatment or to exacerbating poverty through catastrophic health payments. Hence, providing access to health care for the poor must be seen as one important driver of equitable growth and should be a key component of a social security system.

Many low and middle income countries have introduced social health insurance schemes in the past. However, usually they only cover employees in the public and private formal sector. So unless a significant formalization of the entire labour force occurs, the large majority of the poor usually associated with the non-salaried and informal sector will remain excluded from social health insurance in the future. Given the above mentioned poverty and growth implications that entails, more and more countries are considering experiments with various health insurance schemes.

To discuss progress in that field and to debate the advantages and disadvantages of different insurance systems, the Institute of Social Studies and the SMERU research institute in Jakarta jointly organized a session with the theme "Securing access to health insurance for the poor" at the Annual Bank Conference on Development Economics (ABCDE) held in Cape Town in June 2008.

In that session two insurance schemes were presented in detail. Asep Suyahardi, Deputy Director for Research at SMERU, presented the Indonesian Askeskin (*Asuransi Kesehatan untuk Keluarga Miskin*), which is a public health insurance targeted at the poor. Wendy Janssens, Researcher at the Free University of Amsterdam presented an assessment of private health insurance schemes, organized as medical aid funds in Namibia and discussed the introduction of new low-cost private health insurance programs in that country. Discussants were Aparnaa Somanathan, Health Economist at



*Treasury South Africa*

the World Bank, Eddy van Doorslaer, Professor of Health Economics at Erasmus University Rotterdam and Robert Sparrow, Development Economist at ISS. Robert Sparrow is also a co-author of the paper on Indonesia's Askeskin scheme. The session was chaired by Michael Grimm, Professor of Development Economics at ISS.

Although Namibia's public health system benefits from - for African standards - high government spending as well as flat and highly subsidized user fees, the system is, as pointed out by Wendy Janssens, characterized by a substantial inequality in access and a generally rather low quality of care mainly due to long waiting times. Namibia has no general public health insurance. In the greater Windhoek area however, the area Wendy Janssens focused on, about 30% of the population were covered by so-called medical aid funds in 2006, i.e. at the time of the survey she draws on. These funds are usually private with the exception of the government health



# insurance for the poor

## Development Economics 2008

fund which insures public employees. Coverage, as one can expect, varies substantially with socio-economic status, employment and income. In the poorest income quintile only 5% of all individuals are insured, whereas in the richest income quintile almost 70% are insured. Individuals with unemployed household heads or household heads employed in the informal sector are the groups with the lowest coverage rates.

Currently, several new low-cost insurance schemes aimed at lower- and middle income employees are being introduced in Namibia. The schemes include HIV/AIDS treatment and counselling in addition to basic primary and secondary health care. They are company-based with employers covering at least fifty percent of the premiums. In order to pool HIV-related risk across schemes and employment sectors, the so-called Okambilimbili project has set up a Risk Equalization Fund for HIV-related costs. The new schemes cover approximately 40,000 individuals. Both programs, the medical aid funds and the Okambilimbili project are explained in more detail by Wendy Janssens in her contribution in this same issue (see page 13).

With respect to Indonesia, Asep Suryahadi explained that in 2004, around 20% of the Indonesian population was covered by some kind of health insurance, most of them specifically designed and targeted for different categories of formal private and public employees. The benefits provided by these insurance schemes varied greatly and they did not necessarily imply that the insured were completely free from financial risk if they faced catastrophic illness. During the 1997/98 crisis the Indonesian government introduced several safety net initiatives that have improved access to health care through targeted price subsidies with some success, such as the health card. However, as pointed out by Asep Suryahadi, these initiatives were also criticized for different administrative

and targeting problems, inferior quality of subsidized care and high remaining indirect costs. Hence, similar to Namibia, access to appropriate health care is clearly lower for the poor. Asep Suryahadi illustrated this by looking at the number of outpatient and inpatient visits across the income distribution. In particular inpatient care in private hospitals is almost only used by the richest two income quintiles. Comparing actual expenditures among the poor with hypothetical expenditures they should have had with similar access to health care as the rich shows also substantial gaps. To compensate for reductions in fuel subsidies, in 2005 the Indonesian Government launched the Askeskin program under which poor households can receive basic outpatient health care and third class hospital care for free. Districts are responsible for identifying and counting the eligible (poor) participants.

In February 2006, the Askeskin program covered about 25 million people, which was roughly 12% of the total Indonesian population. Although 70% of the people covered are with the poorest 40% of the population, almost 12% of all individuals covered fall into the richest 40% of the population. Hence, as noted by Eddy van Doorslaer, although the program did disproportionately reach the poor it shows a considerable leakage to the non-poor. Asep Suryahadi stressed that the Askeskin cards are in principle free but that prospective participants were asked to pay for photographs and these additional costs probably made the scheme unaffordable for many households in particular for those with many children. The discussions also showed that in terms of impact the program is not particularly pro-poor, because even if utilization increased significantly among all Askeskin participants, the largest increase could again be observed among the non-poor, in particular for inpatient care. This bears in principle the risk of a "*Matthew effect*", so explains Eddy van Doorslaer, where "the rich get richer and the poor

get poorer". Asep Suryahadi explained that service provision is also hindered by the fact that travel distance and related costs still remain a barrier for many poor households. In the coming years the Indonesian government wants Askeskin to scale up to 60 million participants. This would of course provide the opportunity to strengthen the targeting performance of the program. However, whether this objective can be met depends on both the criteria employed by district governments to identify the poor and also how the Government deals with fiscal problems and problems related to the compensation of providers and reimbursements, which presently challenge the program.

However, despite all these caveats both cases – Namibia and Indonesia – suggest that health insurance mitigates shocks and protects households from serious income shortfalls. In Indonesia the use of outpatient and inpatient care was significantly higher among participants in Askeskin than by non-participants. In Namibia, the data allowed also to look at the impact of specific health shocks on different types of income and consumption for the insured and uninsured. These data were collected before the introduction of the new Okambilimbili-supported insurance schemes. The results show that for instance the uninsured face on average lower non-food consumption and a higher uptake of credit following a shock than the uninsured who do not experience a severe health event. They are also more likely to have lower assets which suggest that the uninsured have to deplete assets to overcome health shocks. Such effects are not found for households with insurance. Both the uninsured and the insured show higher unearned income after a health shock which suggests that they benefit from transfers of relatives and friends. Both discussants, Eddy van Doorslaer and Robert Sparrow, highlighted the methodological problems related to such impact evaluations if they do not rely on a randomized survey design.

Robert Sparrow put forward selection problems in analyzing the Namibian case, given that richer households are more likely to participate in the private health insurance. However, the upcoming second survey round in Namibia will be able to account for such selection effects. Eddy van Doorslaer pointed to the possibility of other unobserved shocks on income which could bias the results for Indonesia and suggested not only to look at absolute utilization levels but also at utilization levels given need, which is probably higher among the poor than the rich.

Another issue which was intensively discussed in Cape Town was whether private provision of health care for the poor is more efficient and socially optimal than public provision. In the particular case of Namibia the private insurance schemes are mostly operating in urban areas, because the country has many remote areas and a wide variation in population densities and, hence, private provision may not be very low cost outside the main urban centres. Aparnaa Somanathan also emphasized that in a country with high income inequality like Namibia, public provision of services may play an effective role in redistributing resources towards the poor; in contrast, steering the poor towards greater use of private facilities, where they would face greater financial barriers to access is likely to worsen existing inequalities. On the other hand, as Wendy Janssens replied, a greater mobilization of private resources through private insurance combined with substantial employer contributions could relieve pressure from the government budget and allow for improvements in the quality of public care for the uninsured. This may become especially relevant as the evolving HIV/AIDS-epidemic in Namibia, at an estimated prevalence rate of twenty percent in 2006, will put increasing strain on the public health system.

Moreover, in the discussions it was emphasized that in many developing countries in other parts of the world, the market share of private insurance has been limited by several factors. First, many low/middle income countries have an insufficient number of high quality provider networks to contract with, and, second, countries have

only a limited capacity for regulation, management and actuarial analysis, all of which might be critical for the success of private health insurance schemes.

A number of legal and regulatory mechanisms are needed to foster a well-functioning market of private insurance, including definitions on standards for market entry, rules for reporting and market exit, and consumer protection mechanisms. Third, a precondition to the development of private insurance entities is a viable financial market because the reserves from premiums collected must be invested to ensure profits over outlays and this profit would probably be critical for the sustainability of private insurance entities. However, there was agreement that all these concerns apply probably first of all to poor and very poor countries and less to Namibia, which has a relatively well developed and regulated private insurance market.

There was also much debate with regards to whether private health insurance is an efficient and equitable alternative to a public scheme for the pooling of risks and resources. Aparnaa Somanathan was sceptical because, according to her argument, private health insurance could create multiple risk pools based on employer group and other factors. This is one of the reasons why the new Okambilimbili project in Namibia has set up the Risk Equalization Fund to pool HIV-risk across schemes and groups, as Wendy Janssens described. Potential inefficiencies might also be caused by asymmetric information between insurers and health care providers and insurers trying to shift part of their financial risk to their members and providers. Private voluntary health insurance might set behavioural incentives to providers and members and enhance typical informational problems related to insurance contracts such as self-selection of high risk individuals into insurance (adverse selection), selection of low-risk individuals by insurers (cream-skimming), avoidance of risk-reducing behaviour by the insured (moral hazard) and supplier induced demand by care providers. The poor would be less likely to be covered than the rich by such an insurance scheme. However, at least for Namibia the medical household data suggest that the occurrence of risk selection and

cream-skimming based on health status is very limited, but upcoming research will investigate these issues further.

A last issue which came up in the discussions was the relationship between the purchasers and the providers of services and whether one system, i.e. public or private, offers significant advantages in that respect. Whereas Wendy Janssens suggested that the private sector might improve efficiency, in particular through the use of output-based contracts, Aparnaa Somanathan saw the potential in strategic purchasing of services where insurers contract on a competitive basis with a range of public and private providers. However, she admitted that this potential can only be used if certain preconditions exist. First, the purchaser needs adequate information to assess provider performance and has to use the results in rate-setting and contracting. Second, providers need some degree of managerial and financial autonomy to be able to react to the incentives set by the provider payment method. Third, consumers must have a choice of providers such that 'the money follows the patient'. Without these pre-conditions, the systems would be subject to abuse and, hence, governance becomes an issue.

At the end of their presentations both speakers, Asep Suryahadi and Wendy Janssens, pointed out that reliable and systematic knowledge in this area is still very limited. Follow-up surveys in Indonesia and ongoing pilot projects aimed at expanding subsidized private health insurance in Namibia and Nigeria will soon allow for the undertaking of further impact evaluation-based research on these questions. They will in particular allow investigating the extent to which there is adverse selection or cream-skimming, the impact on equity in access, and whether these programs do indeed have a positive effect on quality and efficiency as envisaged. For Indonesia, the crucial question will be whether the Askeskin system is fiscally sustainable and whether it improves in targeting the poor. In more general terms, for many very poor Sub-Saharan African countries the challenge is of course first of all to create the institutions necessary to implement such insurance systems.

# A Unique Low-cost Private Health Insurance Program in Namibia: Protection from Health Shocks Including HIV/AIDS

Wendy Janssens

*Amsterdam Institute for International Development; VU University of Amsterdam*

Emily Gustafsson-Wright

*Amsterdam Institute for International Development; Brookings Institution*

Ingrid de Beer

*PharmAccess Foundation*

Jacques van der Gaag

*Amsterdam Institute for International Development; Brookings Institute; University of Amsterdam*

Africa today is bearing an extraordinarily large health burden as the epidemics of HIV/AIDS, tuberculosis, malaria and the opportunistic infections associated with some of these diseases put increasing demands on the healthcare sector. Health risk is one of the severest risks confronting poor households. Apart from the personal suffering it brings, illness can cripple a poor household's income earning capacity. Sick individuals can no longer contribute to household income. On top of that, households must allocate resources to provide care within the family and cover the expenses of treatment. More than 150 million people globally suffer financial catastrophe every year due to out-of-pocket health expenditures. The surge of HIV/AIDS-related illnesses and deaths only exacerbates this problem. In the absence of access to free and good quality public care or health insurance, households are forced to resort to alternative coping strategies. However, for low-income households the depletion of savings, assets, or human capital may lead to a further eroding of their already poor asset base. For example, children might have to decrease their time in school and start working for income, care for their ill household member or take over domestic chores. In such circumstances, the benefits of health insurance schemes that include HIV/AIDS treatment are potentially large.

Currently, our knowledge is limited with respect to the impacts of private health insurance on health care utilization, health status and financial

risk protection. In this article, we initiate a policy discussion around the potential role of private insurance to buffer health shocks, especially in the

face of HIV/AIDS. We present a case study of Namibia where the Dutch organization PharmAccess has initiated a pilot program introducing the concept





Katutura Medical Centre - Windhoek, Namibia. PharmAccess Foundation

of low-cost private voluntary health insurance products.

### THE STATE OF HEALTH AND THE HEALTH SECTOR IN NAMIBIA

Namibia is a lower-middle income country with a GNP per capita of US\$6,960 (the African average is US\$2,074). However, this number conceals the enormous differences in wealth within the population. In fact, Namibia has one of the highest levels of inequality in the world. The richest 10 percent of the population receive 65 percent of the country's total income, while approximately 35 percent of the population live below the poverty line of US\$ 1 a day.

The Namibian population suffers from three major communicable diseases; HIV/AIDS, tuberculosis and malaria. These three diseases are the first, second and third major causes of deaths in hospitals respectively (WHO 2004). HIV/AIDS prevalence rates increased from 4.2% in 1992 to 19.9% in 2005. There was a substantial drop in life expectancy due to the HIV/AIDS epidemic from 60 to 52 for males and from 63 to 55 for females between 1991 2004 (WHO, WHOSIS, 2006). Currently,

approximately half of the 45,000 individuals in need of antiretroviral therapy (ART) are receiving treatment. In a few years, the total number of individuals in need of ART could be well above 200,000 as infected people increasingly develop AIDS. This will put a tremendous strain on the health sector.

Over the past two decades, there has been considerable improvement in the public health care sector. After independence from South Africa in 1991, the Namibian health system was very fragmented. Most health facilities were concentrated in the urban areas and segregated along racial lines. Since then, a strong political commitment to upgrade the primary health care system has made health services more responsive to the needs of the population, albeit at a slow pace (WHO Country Cooperation Strategy, Republic of Namibia 2004-2007).

As health is one of the government's priorities, Namibia is now among the top tier of African countries with respect to health expenditures. Over the period 1993 to 2000, 11 percent of government spending was earmarked

for health (WHO 2004). The country has one of the highest total expenditures on health as percentage of GDP - 6.8 percent - nearly 70 percent of which are government expenditures (WHO, 2006). Not only is government health spending high in relative terms, but out-of-pocket expenditures as a proportion of private health expenditures are 18 percent; the second lowest among African countries, surpassed only by South Africa. These figures, however, camouflage the large inequities in access to health care services between rural and urban dwellers, and between the rich and the poor. Although in principal public health care is freely available, in practice the public sector suffers from long waiting times, absenteeism among health workers and other ails.

The Namibian health insurance industry is relatively well developed and primarily organized into medical aid funds that are either open or closed. Closed funds limit membership to employees in a particular firm or industry: the closed government health fund PSEMAS is the largest such scheme, insuring 43 percent of all insured individuals. On average employers pay 38 percent of the premium, although for PSEMAS the employers contribution is just below 20 percent.

In the Greater Windhoek Area, over thirty percent of individuals are enrolled in a medical aid fund. Enrollment is equally likely for men and for women. Nevertheless, enrollment levels are substantially higher for male-headed household members (37 percent) compared to female-headed household members (22 percent). In addition, there are large discrepancies in coverage across socio-economic categories. Only five percent of individuals in the poorest consumption quintile are enrolled in medical aid schemes, while 70 percent of individuals in the richest quintile have medical aid benefits. Medical aid enrollment shows a similar pattern across education levels. In addition to income and education differences in insurance enrollment, there is also a differentiation by industry of employment. Those most likely to be insured are individuals whose head of household works in government or defense. The least insured industries are manufacturing, retail/accommodation and construction.

Not surprisingly, the employed are more likely to be insured than the unemployed.

### THE ECONOMIC CONSEQUENCES OF HEALTH SHOCKS

Based on a dataset collected in Greater Windhoek in 2006, we estimate the mitigating effects of private health insurance on the relationship between health shocks and economic outcomes. Overall, we find no evidence that health shocks have severe economic consequences for households that are enrolled in a medical aid fund. In contrast, households without health insurance suffer from large medical expenditures after the death, hospitalization or problematic weight loss of an adult household member, despite the free access to public care. Although gifts and support from others help them to overcome part of the financial burden, findings suggest that they need to resort to additional coping strategies, such as selling assets, decreasing non-food consumption or taking up loans.

Perhaps surprisingly, the results do not show substantial effects related to HIV-infection. As most HIV-positive individuals do not yet suffer from physical symptoms, weight-loss can be taken as a proxy for a more advanced state of AIDS. Weight loss is not only associated with high costs for medical treatment but also with substantially lower labor productivity and earned income. Remittances from others are significant but not sufficient to compensate for all consequences of the health shock, as the higher use of credit among affected households suggests.

This finding is particularly worrisome in view of the high HIV prevalence in Namibia. Our survey, which also includes medical testing for HIV-infection, shows that individuals who are most likely to be infected are also the ones least likely to have health insurance. As an increasing number of infected people without insurance develop AIDS over time, households' coping abilities, their social support networks and the public health system will come under increasing pressure.

### A POTENTIAL WAY FORWARD

In an attempt to address some of Namibia's health care challenges, a

pilot project initiated by the Dutch organization PharmAccess in 2004 sought to provide low-cost private health insurance for low-income workers, including HIV/AIDS treatment and care, using private sector insurance companies. With these new products, output-based contracts were developed between insurers and health care providers to guarantee easily accessible and high quality care. Health providers would be carefully monitored to ensure that quality standards were maintained. Payment of providers on a per-capita basis instead of a fee-for-service basis would help keep the schemes financially viable. The concept behind the so-called Okambilimbili program was based on the idea that the private sector has under-utilized resources that can play a significant role in scaling-up health care services. Employing the private sector also provides the ability to enforce strict quality standards using output-based contracts where regulatory control is weak. Moreover, financing health through insurance would be efficient because it provides predictable revenue streams and encourages investment in the health sector. In addition, using private resources (household contributions and employer contributions) frees up public funds which can be used for the poorest of the poor who cannot afford insurance and therefore cannot use anything but public health care. Finally, providing health care for the low-income but economically active population has strong economic benefits, enabling an increase in participant and employer payments of the insurance premiums, thereby increasing the sustainability of health financing.

Because private insurance companies in Namibia are interested in establishing their own low-cost health insurance programs, the key feature of the Okambilimbili program became the establishment of a risk equalization fund (REF) for HIV-related expenditures. In this fund, the privately insured groups contribute monthly premiums to a risk pool with a defined set of HIV/AIDS treatment benefits. Thus, the insurance industry can share the risk related to the high HIV-prevalence in Namibia in order to keep their low-cost products financially sustainable.

The emphasis of Okambilimbili is on selling insurance through employers, rather than to individual workers. Many employers currently face substantial costs due to health-related absenteeism and productivity loss among their workers. Indeed, there is a substantial demand from employers for the new low-cost insurance schemes. Of the twenty-five companies that were approached by PharmAccess to take part in the Okambilimbili project, twenty-four were keen to participate in the new products. Employers are required to contribute at least a 50 percent employer subsidy of the premiums, thereby keeping the products affordable to their mostly low- and middle-income employees. At present, over 40,000 people are benefiting from the new insurance products.

In conclusion, despite the relatively well-functioning health care system in Namibia, uninsured households run considerable economic risks from health shocks. Although medical expenses are low on average, acute illnesses and injuries represent a large financial burden for low-income households. This provides substantial scope for risk-pooling through insurance. However, the lower quintiles are least likely to be insured, due mostly to the high premiums of traditional insurance schemes, making them unaffordable for the poor. Since 2004, the Okambilimbili pilot project has introduced new low-cost, thus affordable, private health insurance schemes in Namibia. Two of the defining characteristics of the new schemes are that they include full coverage of HIV/AIDS treatment and care, and that they pool HIV-related risk to ensure financial viability of the schemes. The expectation is that these programs will 1) allow for better basic health care for low-income workers and their families; 2) protect individuals against health shocks including those related to HIV/AIDS and the potentially negative mitigating behaviors associated with shocks; 3) relieve some of the burden on the public health sector; and 4) improve productivity of workers (as a result of better health) and in the long-run, the economic growth of the country. Evaluations of the program are currently ongoing to quantify the impact of the insurance schemes.

# Social Security and Population Ageing in Sub-Saharan Africa

Mahmood Messkoub

Demographic changes that are currently underway in Sub-Saharan Africa (SSA) due to a decline in fertility and AIDS in high prevalence countries call for fresh thinking on social provisioning and social security issues. Here we provide a brief account of these changes and their impact and draw on the experience of other developing countries that started their demographic transition earlier, in order to explore policy lessons for SSA.

The current age structure in Sub-Saharan Africa is one of the youngest in the world, yet fertility rates in most SS African countries, like elsewhere in the developing world, are falling with the result that the proportion of older people in the population will be doubled by the middle of 21st century. Fertility decline should be viewed as an opportunity by countries with a young age structure. However, it is important to note that because of earlier episodes of high fertility, the working age population will be growing in Africa over the next 30-40 years, whilst the size of school age population will decline. This provides a golden opportunity for improving the quality of education and the labour force, thus increasing the resource base needed to manage the rise in the dependency ratio (old/working age) and to care for an elderly population.

On the negative side, these trends are compounded by the epidemic rise of HIV/AIDS in parts of SSA. This has resulted in high death rates and lower life expectancy, especially among those in the most productive age groups of 20 – 65. Notwithstanding the human tragedies of AIDS, it is the impact on the productive capabilities in SSA that is of concern. The loss of such a large section of the labour force is undoubtedly going to affect labour-intensive sectors of the economy, in particular small scale farming. Whilst high unemployment and a youthful age structure would in part compensate for the loss of unskilled labour, skilled labour takes longer to replace.

The other effect of the AIDS/HIV epidemic is on the availability of care within the household and family for both children and the elderly. The traditional care givers - women - are as equally affected as men by HIV/AIDS in SSA. The loss of these carers could increase the risk of malnutrition and infectious diseases among children. The elderly would not only lose an important source of support for their own needs, but would also have to take on the role of care givers for the orphans in their household (UN, 1995).

Strategies designed to ensure the entitlement of the elderly to a reasonable standard of living are not fundamentally different from those designed for other dependent sections of the population. The key policy issue is not only how to tackle the welfare needs of the present elderly generation, but how to help the future generation of the elderly, who are potentially more numerous, to maintain their standard of living.

The elderly are a differentiated population in terms of their ownership of assets and sources of income that in turn determine their entitlement to goods and services. The elderly's income can be based on any combination of ownership of assets: own work, social security, pensions, marital status, other family members, etc. Available data on their sources of income in developed and developing countries show, that in general the richer the country the higher the percentage of those above the age of

60 relying on pensions/welfare for their livelihood. In low income countries, except in urban areas of China, family and own work are the main sources of income. The data also suggests that as countries get richer, formal systems gain importance in providing support to the elderly.

Family is a much more important source of income for the elderly in Africa than elsewhere in the developing world. In Africa the informal systems are based on broader familial links than in Asia. The extended family could contain adult brothers and sisters as well as children. Reliance on the younger generation is not limited to one's own blood children: the practice of adoption, fosterage, raising grandchildren, all help to widen the support base. Another source of informal support in Africa is the existence of kin, community and tribal support (World Bank, 1994). Migration has also played a complicated role in the development and maintenance of informal systems: it provides extra cash income that alleviates poverty, allowing the household to support its non-migrating members, including the elderly. This is predicated on the maintenance of links between the migrating members and the family, thus allowing the migrating members to come 'home' on retirement to be cared for by their family and the larger community. Such links are easier to maintain under circular patterns of migration, which are common in parts of SSA.



Informal systems, however, are not without costs, not all of them monetized, and not necessarily spread equally across household members. Women bear the main burden of caring for the elderly. At times, health costs could be prohibitive and undermine the resource base of the family by forcing the sale of valuable assets. In some households the demographic balance could also shift heavily against the younger generation, putting the care of a rising number of elderly beyond their financial and physical capacity. The latter point is particularly important in SSA where AIDS is affecting those of working age. The table is turned on the elderly who now have to care for their dying children and look after their grandchildren.

As far as any formal old age care and social security system is concerned, the first objective is to protect or to provide aged people with the entitlement to a basic standard of living in line with their lifetime experience and the expectations of the society concerned. The second objective is to reduce the gap between different sections of the elderly. While the first objective can be achieved under a variety of institutional arrangements, the second objective requires some degree of state intervention.

Currently, the main pension schemes in the great majority of SSA countries are earnings related and cover formal sector employees who are predominantly urban based. Botswana is the only country with a universal pension scheme, while South Africa operates a means tested scheme. A few other countries operate a means tested scheme alongside their earning related schemes. Several countries also operate a Provident Funds scheme (a compulsory savings plan) that provides a lump sum on retirement or modest pensions and other contingencies, depending on its governing rules and regulations (ISSA, 2005).

Considering the limited population coverage of most of these schemes, they should be complemented with a range of policies that address the needs of the growing elderly population. In this respect there are valuable lessons to be learnt from the experience of

East Asian countries that, like those in SSA, had relied on their traditional family structure for old age care. This was complemented by a range of policies that provided support for the family extended the coverage of formal schemes.

An obvious starting point in many of the E. Asian countries was the identification of the elderly's needs. Prioritising needs allowed the state to meet these selectively and within its budgetary capacity. In general, support is means tested in E. Asia and targeted towards the poor. All include some basic health and income maintenance support that work as a safety net to cover those who are most in need among the elderly. In addition, formal sector and state

employees are entitled to a secure contribution-related pension.

Drawing on these similarities, the issue of ageing in SSA could be addressed at various levels. At macro level, and following Singapore's model, the ageing should be given a permanent and prominent presence at national level policy making fora. This process could begin by setting up an inter-departmental committee whose members would be drawn from, for example health, social security and welfare ministries, and voluntary organisations. Open and democratic debate is essential for the formulation of correct and legitimate policies. The legitimisation issue is important for the public's acceptance and implementation



*Esther aged 75 from Nakawa Division in Uganda. She supports a family of six grandchildren.  
Ddungu Racheal Mugabi*

of policies and for maximising donor's assistance.

Another important feature of E. Asia is its macroeconomic and price stabilities. Before the economic crisis of late 1990s, E. Asia had enjoyed long periods with a stable macroeconomic environment with low inflation that maintained the purchasing power of the elderly's income. Whilst macroeconomic stability is a general policy goal, more specific policies like indexation of the elderly's income to the consumer price index has to be enacted in order to assure people who are making plans for their retirement in 20 to 30 years time that the value of their savings will be protected.

Moving on to the informal and the household support system, as far as the family source of income is concerned, there are no hard and fast rules, except the general principle of supporting the economic base of the informal system of care for the elderly. At macro level this means supporting the agricultural sector: in general, the rural economy is important in SSA as it is where the majority of the elderly live. Another area of intervention is communication between rural and urban areas. The rural to urban migration of younger people could weaken the link between the two generations within families, and increase the level of uncertainty for the elderly who rely on remittances. Improving the flow of information and communication between the two areas and offering incentives for remittances could help to maintain the economic and social links between the two areas and between generations. Maintaining and encouraging generational solidarity is not without its costs, especially for the poor young households who have to and will share their meager resources with their elders. Some young households may not be able to save and accumulate resources essential for investment to raise their productivity. That is why public action and state support is essential to complement household support.

States in E. Asia provide a range of services such as health insurance, medical tests, pensions, income support and tax relief that in general complement rather than substitute those provided by families and other institutions. Some of these services,

like pensions, take longer to set up or extend their coverage in SSA, whilst others could be implemented quickly, such as tax relief to families caring for their elderly, and health support. Complementarities between formal and informal systems in the era of cutbacks in state welfare budgets means that any cuts should ensure that the income of families caring for the elderly is protected when it comes to charging of fees and cuts in public services.

In South Korea and Singapore work has been used as another measure to maintain the economic independence of the elderly and to alleviate the pressure on labour supply shortages. S. Korea established job placement schemes for retirees and the elderly. For example, the elderly have been helped to set up workshops and share the income, or have been given priority for setting up stalls in public places such as parks to sell basic necessities and government monopoly goods. This policy can easily be adopted in SSA. To ensure that the benefits of such preferential treatment would not go only to those who have the skills and the capital to set up a small business however, this policy has to be complemented with the provision of small loans and training. Micro-credit institutions could help in this regard, and could also be used to build up pension funds for the poorer sections of the population. The potential downside of supporting the elderly to set up small businesses – competition with existing businesses in the informal sector – should not be of major concern given the relatively small number of elderly involved.

Africa has a rich history of looking after its older generation. In designing policies, due attention should be given to the existing institutional arrangements, both informal and formal, by trying to increase the complementarities between the two. The cost of running pay-as-you-go pension schemes would be lowered if household-based arrangements for the care of the elderly could be maintained. Providing financial incentives to households to care for their elderly should be part of the planning for population ageing. Strengthening the financial and other infrastructural links between rural and urban areas should also help migrating members of the

household to look after the rural-based older generation.

The establishment and reform of the formal system is a much more problematic policy area. The existing pension schemes have a very limited coverage in SSA and in the main are restricted to wage earners. Expanding their coverage may be beyond the financial capacity of many African governments. Establishing private pension schemes, fashionable as it is, requires a strong regulatory infrastructure of the financial sector. As a first step, such regulatory frameworks have to be put in place, while developing and strengthening the financial sector.

Within the formal financial sector, provident funds have offered a certain degree of support to the elderly. Converting them into pension funds could come at the expense of the contingency function of these funds for the contributors. If people have to increase their savings for contingencies, their ability to contribute to a pension fund may well be eroded. The reform of provident funds has to take account of the various functions of these funds by trying to establish different instruments for the main functions - pension funds, micro-savings/credit funds, grant based means tested financial support, etc.

Social policies have to take account of the heterogeneity of the elderly in terms of their social and economic background and their areas of residence (rural or urban). Formal pension schemes more often than not cater for the urban based middle and upper strata of the population. The rest are too poor to meet the requirements of the formal sector. The formal financial sector in most developing countries has not in general been a source of financial service and assistance to the poor. Development of micro-financial organisations with the aim of providing financial support to the elderly should be an integral part of government planning for old age. Finally, a more general approach to the care of the elderly has to be established in which the needs of the aged are integrated within the support provided for the community which is expected to care for them.

# Remember Tobin?

## *Finance driven crisis & Civic driven response*

Louk Box



The global financial crisis of autumn 2008 may turn into a disaster for the poor if we do not understand the signs of the times and translate them politically. The crisis started out as a financial one, due to a combination of US government deregulation with artificially low interest rates, leading ultimately to what we now know as the loss of interbank confidence due to sub-prime mortgage defaults. In hindsight, the crisis was inevitable, and international bankers are responsible for having traded polluted or poisonous products. They were free to trade such products because nobody was there to control them; some of them may not even have known how poisoned their products were.

This crisis reminds many observers of a previous one in the 1930's. It was the crisis that led to mass unemployment in the countries concerned, to a lack of trust in the State and in some cases to fascist governments, and ultimately to the horrors of the Second World War. It also led to an intellectual reaction which shaped post-war social science

thinking. In fact, the very creation of the Institute of Social Studies can be seen in this light. The reaction against disciplines which had not envisaged the consequences of the crisis led to a multidisciplinary approach. The horrors of mass unemployment led to Keynesian economics; the horrors of the Shoa led to social-psychology's fascination with the Authoritarian Personality; the horrors of poverty led to the need for the State to take its responsibility, as people like Tinbergen argued.

The present crisis may have the same effects on the poor if we do not read the signs of the times. Again, States are forced to reduce the effects of a crisis in the capitalist world system to the tune of trillions of dollars. Again, social science disciplines may be criticised for not warning in time. Again this may lead to populist anti-democratic movements leading to mass migrations or even genocide. The prevailing Neo-Liberal consensus espoused by leading politicians, academics and business leaders may be intellectually broke, it has nevertheless shaped many of the institutions that are presently asked to pick up the pieces left by the crisis.

Yet there are alternatives. Academics, grass-root intellectuals, civic leaders and social entrepreneurs have worked over the past year with ISS scholars Biekart and Fowler on a programme called Civic Driven Change. This autumn they edited a book by that title, subtitled *Citizen's Imagination in Action*. Together with authors from Bolivia, Brazil, Finland, Hungary, India, Kenya, South Africa, the UK and the US they built "a perspective of change in societies that stems from citizens rather than states or markets." They go beyond the cosy arrangement

that NGOs created for themselves under the Neo-Liberal consensus, taking over public functions from the State in social and other sectors. The real question now becomes: how can citizens exercise their civic and other rights through responsible agency?

Under the Neo-Liberal Consensus it was considered self-evident that the State could not control global finance. The amounts of the exchanges were simply too large; the speed with which global capital transfers were made, simply too great; the expertise to control such capital simply too complex to assume that governments could muster it. When US Secretary Paulson prepared his US\$700 billion package he disproved the Neo-Liberal Consensus. Nicolas Sarkozy and Gordon Brown confirmed it when the stock-exchanges responded positively to their State interventions.

Yet where is the citizen's response to the crisis? Is it limited to pensioners' grudges that their promised income is reduced by one third or more? Is it limited to the small share-holder's anguish to have seen the value of her assets cut by half or more? Is it limited to the tax-payer's concern in rich countries worrying about the future tax burden?

Maybe all of these, plus a global civic driven change for greater control over financial flows within and between countries. For we did learn one lesson from the previous crisis: the poor are the first to bear the brunt if the State is not there to secure their rights.

Remember Tobin? Now is the time for a global movement to sustain an adapted version of his tax.



# The financial crisis and developing countries

Karel Jansen

Since the Asian crisis in 1997 I have been teaching about financial crises. My examples were developing countries like Mexico, Thailand, and Argentina. In my next course I will have to shift my focus as today arguably the biggest financial crisis ever is unfolding in the USA and Europe. The amounts involved are mind-boggling and governments are intervening in ways that, till recently, were unthinkable. This short article aims to give a brief explanation of the crisis and provide a first sketch of possible implications for developing countries.

The crisis started in the summer of 2007 when problems with sub-prime mortgages emerged in the USA. The very existence of sub-prime mortgages can tell us something about the financial system. Why were mortgages given to people with low and unstable incomes and weak credit histories?

Two reasons may be suggested. The first is that credit was abundant and cheap and banks were eager for income earning opportunities. The ample credit supply was the result of loose monetary policies, e.g. in the USA and Japan. The low interest rates stimulated expenditure, resulting in very large current account deficits in the USA; these deficits were financed by the surplus savings of China and the oil states. The second reason relates to risk management. Sub-prime mortgages are risky as the probability of default is higher than on standard loans but investors could manage these risks through the use of derivatives. The sub-prime mortgages were packaged in mortgage-backed securities (MBS), 'tiered' into risk slices. The holders of the most risky tier would feel the pain immediately when the underlying mortgages started to default but the holders of the upper tiers would only be affected in the unlikely event that the majority of sub-prime mortgages would default. Credit rating agencies gave these upper tiers triple-A ratings which made them attractive for institutional

investors. The lower tiers were bought by investors able and willing to run more risk. Another derivative instrument used to manage risk is the Credit Default Swap (CDS), a type of insurance policy in which the seller of the CDS will compensate the buyer if the value of the underlying asset (e.g. MBS) declines.

The MBS and CDS are only two forms of derivatives traded on financial markets, many more products exist. The total amount of derivatives outstanding at the end of 2007 was 596 trillion USD, up from 95 trillion at the end of 2000. To give some perspective: the 596 trillion is about nine times the global GDP. From these numbers it is clear that the derivative market is not driven by the needs of the real economy, rather it has become a market for financial speculation.

Through such instruments, it was believed, risk could be managed. However, once the crisis started it turned out they did not work as well as expected. As mortgages started to default, the value of the MBS declined and the financial institutions that held these securities or had sold CDS against them started to incur losses. The losses suffered by these institutions undermined market confidence in them and they started to find it difficult to do

deals on the financial markets. The loss of confidence was reinforced by the slowdown in the real economy. In 2008 analysts started to predict a recession in the USA, Japan and Europe. It is tempting to conclude that the derivative products have become so complex that few understand the risks they contain. This ignorance and uncertainty becomes deadly when markets turn and confidence falls: at that stage, trade in these products stops and financial markets stop to function.

In September/October 2008 things came to a head: banks and mortgage institutions collapsed or were taken over or nationalized. The weekend of 11/12 October saw frantic political activity. In Washington the G-7 met, followed by meetings of the IMF and the World Bank and a meeting of euro leaders in Paris. The message coming out of these meetings was loud and clear: governments of advanced countries would do whatever necessary to stabilize the financial system. In the USA, Congress has allocated USD 700 billion for the Troubled Asset Relief programme (TARP). The European solution aims at a more direct strengthening of banks' balance sheets through the infusion of new capital. Very importantly, governments give a guarantee for interbank loans in an



Indian investor watches share prices on a digital stock ticker outside The Bombay Stock Exchange (BSE) building in Mumbai on October 8, 2008. ANP

attempt to get financial markets working again.

At the time of writing (October 2008) the crisis is unfolding and its impact is difficult to predict. The cost of restoring the financial system will be considerable and this will have effects on the real economy as well through the loss of wealth, the higher cost of borrowing and through fiscal stress. The economies of the advanced countries are thus likely to go through a difficult period.

The impact on developing countries will be varied. The direct financial impact may be limited. Banks in developing countries do not have large holdings of troubled assets. But banks, and corporations, will find it more difficult and more costly to borrow on international markets. This could affect particularly developing countries that need to finance current account deficits. Those countries that are more integrated into global trade will feel the strongest effects as the recession in the rich countries will reduce demand for imports and is likely to result in falling commodity prices. The recession in the West and the decline in oil prices will reduce workers' remittances. Stock markets around the developing world have collapsed as foreign investors withdrew funds, needing all the money they could find to shore up their balance sheets at home. It is not unlikely that the fiscal pressures caused by the financial rescue operations of Western governments will reduce aid flows.

The higher cost of credit, the decline in export earnings and weak stock markets

are likely to affect the confidence of investors, both domestic and foreign.

There is thus enough reason to expect that the short and medium term impact on developing countries will be a slowdown of growth. The extent of the slowdown depends on how deep the recession in the rich countries is going to be and on how quickly financial markets can return to normal operations. Those developing countries that have current account surpluses and large stocks of international reserves can stimulate domestic demand to compensate for the fall in exports; for instance, a sharp increase in consumption in China could provide a welcome stimulus to the global economy.

The recession will be temporary. In the longer run the implications of the crisis are complex. Many expect that the financial system that will emerge from the crisis will be simpler and more regulated. Derivatives will remain as they are useful instruments to manage risk, but the experience of the crisis will cut the excess and government regulation is likely to increase the capital requirements for banks holding the derivatives (which will reduce their profitability). Governments that have invested in salvaging the financial system will take their pound of flesh in the form of tighter regulation and supervision. We will thus go back to a system of simpler and more straightforward financial intermediation. If this prediction were to materialize, developing countries may well benefit. Western investors in search for returns may recognize that investments in developing countries offer good

opportunities for return and risk diversification.

It is also interesting to speculate about the political economy aspects of the crisis. Many are already arguing that the crisis spells the end of the dominance of the neo-liberal paradigm. The Washington Consensus is dead: state ownership and state regulation are back with a vengeance. I am not so certain: financial capital has suffered a severe blow and is likely to be a less effective promoter of liberalization, but multinational capital is still there and remains a powerful force for free markets.

Others see in the crisis the end of US hegemony. The unilateralism of the Bush administration had already undermined the US position in the world and the financial crisis weakens an essential pillar of US power. The USA is already running large fiscal and current account deficits and the financial rescue plan will have to be financed by borrowing from China and the oil states. It is, however, possible that China will experience a fall in exports and foreign investment so that the surplus declines and the falling oil prices will cut the surpluses of the oil states. Can they continue to finance the USA? Moreover, these countries already hold substantial dollar assets through their international reserves and through their sovereign wealth funds. It is likely that they have suffered losses on some of these assets. How eager will they be to get into more dollar assets? And will these creditors sullenly provide the required cash or will there be economic and political conditions now that the USA is weakened?

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### Staff news

**Susan Spaa**, has joined the Student Office.

**Bram Buscher** has joined as lecturer in Rural Development, Environment and Population.

**Andrew Fischer** has joined as lecturer in Population and Social Policy.

**Jane Pocock** has joined as editor of DevISSues and ISS website.

**Bridget O'Laughlin** and **Eric Ross**, both Associate Professors in Population and Development have left after more than 15 years at ISS.

**Admasu Shiferaw** post doc researcher and lecturer in SG1: he has left per 1 October.

## Development and Change

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